Statewide Transformation Initiative
Mental Health Benefit Package Design
Final Report

Executive Summary

submitted to

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Mental Health Division

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Executive Summary

The Washington State Mental Health Division (MHD) contracted with TriWest Group to provide policy guidance and input regarding potential redesign of its benefit package for publicly-funded managed behavioral health care. This work is one part of MHD's broader System Transformation Initiative (STI). Building on the findings and recommendations of a preliminary report submitted in February 2007,[1] this Final Report integrates a review of comparison states, Washington's benefit design and management processes, national evidence-based and promising practices, Deficit Reduction Act options, and rate methodologies into a final set of options and recommendations for MHD. The recommendations include:

1. Recommendations related to how best to promote current national best practices for adults and older adults, as well as children and families, within the overall recommended benefit design, and
2. Recommendations regarding Washington's Medicaid State Plan and overall mental health benefit design.

Recommendations Related to Mental Health Best Practices

System Level Recommendations for Promoting Best Practices

Best Practice (BP) Recommendation #1: While continuing to promote Evidence-Based Practices (EBPs), be mindful of their limitations. Inherent limitations in the research base for evidence-based practices (for example, a lack of research that addresses the complexities of typical practice settings such as staffing variability due to vacancies, turnover, and differential training) often lead providers, consumers, and other stakeholders to question the extent to which EBPs are applicable to their communities. In addition, many consumers are understandably concerned that having policy makers specify particular approaches might limit the service choices available, and many providers are reluctant to implement EBPs due to the costs and risks involved in training and infrastructure-building, processes that require commitments over years rather than months. Successful EBP promotion begins with an understanding of the real world limitations of each specific best practice, so that the inevitable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort.

BP Recommendation #2: Specifically address the lack of research on cross-cultural application of EBPs. There is wide consensus in the literature that little research has been carried out to document the differential efficacy of EBPs across cultures. Given that few EBPs have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that EBPs be implemented within the context of ongoing evaluation efforts to determine whether they are effective for the local populations being served.

[1] See the following website for a full copy of that report: http://www1.dshs.wa.gov/pdf/hrsa/mh/Mental_Health_Benefit_Package_Design_Report_DRAFT_4_16_2007.pdf.

BP Recommendation #3: Specify the level of consumer and family involvement for each service in the array of best practices to be promoted. The best practices described in this report include a range of consumer and family involvement that varies across practices. In this report, we define the degree to which the best practices reviewed are consumer and family driven, focusing on the levels at which the services involve consumer and family member guidance and input through the following scale:

- **Consumer/Family Run and Operated –** Services delivered by consumers or family members within organizations that are majority owned or otherwise autonomously governed and run by at least 51% consumers or family members.
- **Fully Consumer/Family Delivered –** Services and supports that are delivered by consumers or family members within organizations that are run by professionals.
- **Partially Consumer/Family Delivered –** Services and supports jointly delivered by consumers or family members in partnership with professionals.
- **Consumer/Family Involved –** Services and supports delivered by professionals that include formal protocols for ensuring and enhancing the involvement of consumer and family members in the planning and delivery of the service.
- **Professionally Run and Delivered –** Services designed to be delivered by professionals within organizations run and operated by professionals.

BP Recommendation #4: Ground the promotion of specific best practices within a broader Evidence Based Culture. The increasingly common approach taken by many states of mandating the use of specific EBPs in and of itself has not necessarily led to improved outcomes and does little to help agencies, provider organizations, and communities understand how best to select and implement effective interventions. States that have been more successful in their implementation of EBPs have focused on the need for system and organizational infrastructures to support the implementation, broad dissemination, and ongoing scrutiny of evidence-based practices. Such infrastructures involve the policy, procedural, and funding mechanisms to sustain evidence-based interventions, and they need to be based in system and organizational cultures and climates that value the use of information and data tracking as a strategy to improve the quality of services and increase the likelihood of achieving desired outcomes (a data and learning-centered construct implicit in an array of constructs, including "learning organizations," "continuous quality improvement," and others). Some researchers use the term "evidence based culture" to describe the constellation of policy, procedural, and funding mechanisms in concert with a favorable culture and climate that support successful practice.

BP Recommendation #5: Develop Centers of Excellence to support the implementation of those best practices prioritized for statewide implementation. There are increasing efforts by states to develop their own local "centers of excellence" (COE) to provide ongoing sources of expertise, evaluation, training, and guidance to support the initiation and ongoing development of EBPs and promising practices. While there are no definitive studies yet available of what factors best support system-wide EBP promotion, emerging research suggests that states implementing COEs are further along in EBP promotion than those that do not. Washington State has its own emerging COEs through its comprehensive contract

with the Washington Institute for Mental Illness Research and Training to develop ACT capacity statewide and the children's mental health evidence-based practice institute at the University of Washington established under House Bill (HB) 1088. The critical components of COEs for promoting EBPs include: training, ongoing technical assistance and support, quality improvement and fidelity tracking, outcome monitoring, and dedicated staff for each EBP promoted.

BP Recommendation #6: Develop encounter coding protocols to allow MHD and RSNs to track the provision of other best practices. Currently, the service codes used for encounter reporting lack the specificity needed to differentiate best practices, complicating the promotion of best practices by providing the same reimbursement across different types of best practices, providing the same reimbursement for generic and best practices, limiting the ability of MHD to monitor best practice availability, and limiting the ability of actuarial analysis to factor in the additional costs incurred by the delivery of best practices that require specialized training, reduced productivity, and/or fidelity monitoring. We recommend that MHD develop additional HIPAA-compliant encounter coding modifiers so that all best practices of interest within the public mental health system are tracked, using a mix of coding strategies, including procedure codes, procedure code modifiers, and program codes identifying specific groups of individual providers within agencies. In addition, protocols governing the use of these codes will need to be defined and enforced.

Recommended Priority Best Practices

To prioritize among the 41 best practices analyzed in this report, criteria were developed that included balancing of the selection of best practices across age groups (children, adults, and older adults) and each best practices' documented potential to reduce inappropriate use of restrictive services (inpatient and residential), promote cross-system integration, support culturally relevant and competent care, and facilitate recovery for adults and resilience for children and their families. These criteria were used to identify five priority practices.

BP Recommendation #7: MHD should prioritize three to five of the following best practices for statewide implementation:

- Peer support services provided directly by **Consumer and Family-Run Organizations**,
- **Integrated Dual Disorder Treatment (IDDT)** for persons with severe co-occurring mental health and substance use disorders,
- **Wraparound Service Coordination** for children with severe emotional disturbances and their families who are served by multiple state agencies,
- **Multidimensional Treatment Foster Care (MTFC)** for children needing intensive out-of-home services, but able to receive care safely in a family-based setting, and
- **Collaborative Care in Primary Care Settings** for populations, such as older adults, most effectively served by mental health clinicians located in primary care settings.

To guide MHD and other stakeholders as they seek to determine the feasibility of implementing these services, TriWest has developed a unit cost methodology for estimating their potential costs. This model was based on the approaches described in the June 2005 Rate Certification by Milliman, Inc., and the approach and specific applications were reviewed in with the actuarial team. Key cost findings based on this model for the five practices are presented below.

Consumer and Family Run Services – We recommend that Washington State establish a new provider type under an amended 1915(b) waiver authority modeled on the State of Arizona's certification model for providers of "non-licensed behavioral health services" referred to as Community Service Agencies (CSAs). CSA staff members providing services covered by Medicaid must meet the same criteria that staff in more traditional provider settings must meet (such as experience and supervision requirements) for any specific service type provided. The primary service type that we recommend covering is Peer Support. Experience, supervision, and documentation requirements in Washington's State Plan and state-level regulations would need to be met.

We estimate that the cost per unit of Peer Support delivered through a CSA is comparable to that delivered currently through a community mental health agency (CMHA). We therefore believe that the service costs for this modality were already added to the system based on Washington's 2005 actuarial study. However, adequate costs to promote the infrastructure necessary to develop CSAs were not. This may very well be a contributing reason to why current levels of peer support provision by most RSNs remain below expectations.

Expanding the current peer specialist certification program into a COE able to promote the provision of Peer Support across an expanded group of potential providers (both CMHAs and the new CSA providers) could help bring Peer Support service delivery up to the levels factored into the current rates. We estimate that this would cost $425,000 a year and be able to be covered within the Medicaid program, therefore requiring $215,000 in state expenditures (to cover the Medicaid match). Further assuming that replacing the $150,000 in federal block grant funding currently spent on Peer Support training could free up State General Funds currently going to pay for other purposes (and thereby allow these State General Funds to be shifted to other mental health priorities), the annual costs would be reduced to $65,000.

Integrated Dual Disorder Treatment. Integrated Dual Disorder Treatment (IDDT) involves the provision of mental health and substance abuse services through a single treatment team for people with severe needs. We estimated the unit costs to provide IDDT to be $780 per recipient per month. Looking only at the Medicaid-enrolled population (which does not include state-funded recipients or people who lose Medicaid coverage during periods of a spend-down), we further estimated that 1% of all Medicaid-eligible adults (ages 19 to 59) would be in need of IDDT services, yielding a projection of need for intensive IDDT services across all enrolled adults of 2,971 adults statewide per year. We also estimated the costs of implementing a COE to support this level of IDDT implementation. To serve 2,971 adults with IDDT, an estimated 37 teams would be needed (each serving 80 people, on average). If we assume that statewide implementation of IDDT will occur over a three year period (20

teams in Year One, 10 additional teams in Year Two, and 10 additional teams in Year Three), we estimate a total annual COE cost of $460,000. We recommend building the COE support into the fee paid to providers given that it represents an additional cost incurred by IDDT providers in order to be certified by the COE as able to deliver IDDT services. As a provider cost, it can be included in the amount reimbursable by Medicaid.

Inclusive of all new costs and backing out anticipated cost offsets and the costs of current service provision, we developed a multi-year cost projection summarized in the table below.

IDDT Multi-Year Utilization Projection				
Variables	**Year One**	**Year Two**	**Year Three**	**Year Four**
Total Teams	20	30	37	37
Core Team Operating Costs	$14,976,000	$22,464,000	$27,705,600	$27,705,600
COE Costs	$ 460,000	$ 460,000	$ 460,000	$ 460,000
Total Cost	$15,436,000	$22,924,000	$28,165,600	$28,165,600
Average Medicaid Recipients Served Per Month	1,000	2,100	2,750	2,960
Medicaid Revenue ($793 per person served per month)	$ 9,516,000	$19,983,600	$26,169,000	$28,167,360
Cost Offsets for Persons Served ($513 per person served per month)	$ 6,156,000	$12,927,600	$16,929,000	$18,221,760
Additional Medicaid Costs (Revenue minus Offsets)	$ 3,360,000	$ 7,056,000	$ 9,240,000	$ 9,945,600
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	$ 5,920,000	$ 2,940,400	$ 1,996,600	$ -

Wraparound Service Coordination. Wraparound Service Coordination is an intervention designed to coordinate a set of individually tailored services to a child and their family using a team-based planning process. It is important to keep in mind when reviewing the cost analysis provided that Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible. To estimate unit costs, we used the staffing model used by Wraparound Milwaukee, a national benchmark program, yielding an estimated unit cost of $790 per month. To estimate potential utilization, we averaged estimates from three RSNs currently delivering a version of Wraparound (Clark, Greater Columbia, King) to yield the projection of 0.56 percent of Medicaid-enrolled children (9.1% of children served) or 3,143 children statewide. This estimate compares favorably with information compiled by MHD regarding the number of children with intensive service needs (December 2006 analysis by MHD based on FY2004 data). We estimate the average utilization per user to be 16 months, based on information from national experts (B. Kamradt, M. Zabel), so the total number of service recipients once the program is fully up and running will be 4,191 (one and one-third times the annual need). In addition, we estimate that it would add an additional $13 per recipient per month to cover the costs of a statewide Center of Excellence to support delivery of Wraparound. The total

cost to deliver Wraparound to a single child per month is therefore $806 in our model ($793 for the core service and $13 for the COE support). The cost per recipient is offset by expected reductions in MHD inpatient and residential costs currently incurred in the system totaling $63 per recipient per month. This estimate likely significantly understates the potential cost savings.

Furthermore, this estimate only covers the Medicaid-reimbursable costs associated with the intervention. It does not include additional funds for ancillary supports critical to the successful implementation of Wraparound, such as flexible funds (which we would estimate at an additional $500 per family per year, which would not be reimbursable under Medicaid), transportation supports, and direct services provided to family members of the covered child.

Based on this, the costs to develop teams and provide Wraparound Service Coordination per year varies by year of implementation as a function of the number of teams implemented each year. The amount of Medicaid revenue that can be earned by each team to support both program and COE costs is a function of how quickly each team can ramp up to full capacity. Assuming that it takes nine months for each team to ramp up to full capacity (serving no people in month one, then adding 8 people a month through the end of month nine), 62.5% of costs for each team in their first year of operation can be covered by Medicaid costs (assuming 100% of people served have Medicaid coverage), summarized in the table below.

Wraparound Service Coordination Multi-Year Utilization Projection				
Variables	**Year One**	**Year Two**	**Year Three**	**Year Four**
Total Teams	22	44	65.5	65.5
Core Team Operating Costs	$13,339,480	$26,678,960	$39,715,270	$39,715,270
COE Costs	$ 500,000	$ 500,000	$ 500,000	$ 500,000
Total Cost	$13,839,480	$27,178,960	$40,215,270	$40,215,270
Average Medicaid Recipients Served Per Month	880	2,288	3,676	4,191
Medicaid Revenue ($806 per person served per month)	$ 8,511,360	$22,129,536	$35,554,272	$40,535,352
Cost Offsets for Persons Served ($63 per person served per month)[2]	$ 665,280	$ 1,729,728	$ 2,779,056	$ 3,168,396
Additional Medicaid Costs (Revenue minus Offsets)	$ 7,846,080	$20,399,808	$32,775,216	$37,366,956
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	$ 5,328,120	$ 5,049,424	$ 4,660,998	$ (320,082)

[2] This figure does not include significant cost-offsets in inpatient, residential and institutional services delivered by CA, JRA, and DASA. Cost-offsets are therefore likely underestimated by a significant factor.

Multidimensional Treatment Foster Care (MTFC). The selection of MTFC as a priority for statewide development centered on the need for additional mental health out-of-home treatment capacity. MTFC is a type of therapeutic foster care provided to children and youth living with foster parents or for families who require an intensive period of treatment before reunification. That being said, it is not clear that the MTFC should be implemented in all instances with rigid adherence to the parameters articulated by its purveyor, TFC Consultants, Inc. It seems critical from our discussions with MHD and Children's Administration (CA) staff closely involved with the current MTFC pilots that some additional flexibility in the model is needed, particularly in terms of the purveyors' insistence that the model operate with 10 beds. To be of use in more rural areas, it seems important that the model be able to operate with fewer beds (i.e., 5 bed models). Given the importance that family-based interventions be carried out close enough to parents and caregivers that they can be regularly involved, allowing smaller programs in rural areas seems preferable to larger programs located further from families.

MHD is currently estimating costs for MTFC in its Kitsap pilot at $184 a day. Of these costs, approximately half ($92) is reimbursable by Medicaid (half of which is funded by the State and half of which is federal financial participation) and the remaining half ($92) must be paid entirely with State Funds. We are recommending that this service be paid for entirely by MHD in order to spare families the need to coordinate with yet another agency. This assumes that, if families are already involved with CA, CA will cover the costs of needed out-of-home care (outside of the cost estimates in this report). The cost estimates in this report cover only the costs of MTFC delivered by RSNs to mental health consumers not involved with CA. We realize that in many cases out-of-home costs are currently split by CA and RSNs. We have attempted to factor this into our cost-offset calculations by estimating reductions in the use of the portion of these services replaced by the MHD-funded MTFC.

Based on discussions with MHD and CA staff, we projected three utilization scenarios:

- Low Range: A primarily acute care model with 105 beds (five 10-bed programs, plus 11 5-bed programs for smaller RSNs) and ALOS of 6 months.
- Mid-Range: An acute and intermediate stay model with 165 beds (seven 10-bed programs, plus 13 5-bed programs for smaller RSNs) and ALOS of 7.5 months.
- High Range: A more intermediate-term care model with 230 beds (18 10-bed programs, plus 10 5-bed programs for smaller RSNs) and ALOS of 9 months.

The total cost to deliver MTFC to a single child per month in all of the scenarios is $2,798 per recipient for Medicaid treatment ($92 per day times 30.4 days per month), $2,798 per recipient for State funds to support room and board ($92 per day times 30.4 days per month). The cost per recipient is offset by expected reductions in the costs of currently delivered outpatient services, plus reduced MHD inpatient and residential costs currently incurred in the system, totaling $1,124 per recipient per month. This estimate likely significantly understates the potential cost savings. In addition, the cost analysis assumes that first year training and fidelity monitoring costs (inclusive of consulting costs and travel) will be $50,000 for each 10-bed team ($25,000 for 5-bed teams, assuming that two 5-bed teams meet jointly with the

consultants). Second year and following costs are assumed to be $10,000 for each 10-bed team ($5,000 for 5-bed teams, again assuming that two 5-bed teams meet jointly).

Based on our analysis, the costs to develop and provide MTFC per year varies by year of implementation as a function of the number of teams implemented each year. The number of teams needed, persons served by the end of the six year implementation schedule, potential cost offsets, and total costs are summarized in the table below for each of the three estimates.

MTFC Multi-Year Utilization Projections			
Variables	**Low Range**	**Medium Range**	**High Range**
Total Teams in Year Six	**16**	**20**	**28**
Full (10 beds)	5	7	18
Half (5 beds)	11	13	10
Total Cost in Year One	**$1,443,200**	**$1,443,200**	**$3,968,800**
Total Cost in Year Six	**$7,156,800**	**$9,201,600**	**$15,676,800**
Average Medicaid Recipients Per Month in Year Six	**105**	**135**	**230**
Medicaid Cost Offsets in Year Six ($1,124 per person served)	**$1,416,240**	**$1,820,880**	**$ 3,102,240**
Additional Medicaid Costs in Year Six (Revenue minus Offsets)	**$1,306,942**	**$1,680,354**	**$ 2,862,825**
Additional State-Only Funding Needed in Year Six ($92 per person served per day, other costs)	**$4,433,618**	**$5,700,366**	**$ 9,711,735**

Collaborative Care in Primary Settings. Collaborative Care is a model of integrating mental health and primary care services in primary care settings. If RSNs are to deliver Collaborative Care, the primary barrier will be the current Access to Care Standards (ACS) that prohibit the delivery of mental health services to people with functional impairments in the moderate (above a GAF/C-GAS score of 50) to mild (above a GAF/C-GAS score of 60) range, depending on diagnosis. A core premise of the delivery of Collaborative Care is that mental health services be provided in primary care settings with minimal barriers. In order to overcome the barriers to the effective delivery of mental health services in primary care settings, mental health clinicians must be willing to take all referrals and not attempt to exclude any persons referred based on functioning.

Much of the leading research nationally related to Collaborative Care is currently conducted by faculty at the University of Washington's Department of Psychiatry and Behavioral Services and Department of Family Medicine. The costs to establish a Center of Excellence for Collaborative Care would depend on the number of sites being implemented. We estimate that a budget of approximately $300,000 would be needed to support the development of 10 teams across the state.

The unit costs for Collaborative Care are comparable to those already reimbursed in the system. The primary driver of any cost increases if Collaborative Care is promoted would be

increased utilization of services. We would not expect any measurable cost offsets within the mental health system attributable to the provision of Collaborative Care, though more effective treatment of depression (the diagnosis most frequently targeted for improved service delivery with older adults in Collaborative Care models) would very likely decrease the use of other health care services. People suffering from depression who are receiving services through the primary care system use three to four times as many services for physical health complaints as people without depression.

Given that current data on unmet mental health needs in primary care settings and the potential cost-offsets in primary health care services costs were not available to this project, it is not possible to give a precise estimate of potential costs for expanded delivery of Collaborative Care in primary care settings. However, we believe that the potential cost increases would likely be in the range of other analyses to expand access for the delivery of mental health care to broad populations such as the recent expansion of Healthy Options and fee-for-service benefit limits. Adding these costs to those estimated for a COE to support Collaborative Care, we would estimate the costs of initial Collaborative Care efforts to range between $1.1 million to $2.5 million annually.

Other Priority Services. In addition to these five priority services for which we completed comprehensive cost estimates based on the unit cost methodology, the report recommends the continued delivery and development of the following best practices by MHD:

- Supported Employment for adults with serious mental illness,
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT) for children and adolescents,
- Parent-Child Interaction Therapy (PCIT), and
- Multisystemic Therapy (MST).

BP Recommendation #8: For any best practices promoted statewide and paid for under Medicaid, conduct a formal actuarial analysis of costs prior to implementation and conduct additional analysis at the end of each year to determine if RSNs have developed the funded services. For any RSN that has not provided the level of targeted best practices that was funded, the difference between the documented costs incurred for targeted best practice services provided and the amount allocated should be paid back to MHD and the federal portion paid back to CMS.

The cost analyses included in this report were never intended by MHD or TriWest Group to be a substitute for actuarial analysis of any change in benefit funding eventually undertaken. In addition, one of the risks in funding services prospectively through capitation payments is that the services funded may not be delivered. We recommend that DSHS allocate additional actuarial time to MHD to allow for analysis of these factors. The specific analyses should be identified and priced by the actuarial contractor prior to carrying them out.

Recommendations Based on Medicaid State Plan Analysis

Washington's Medicaid managed mental health care system has undergone several significant developmental changes since 2002. These include development of the Access to Care Standards and significant changes to the State Medicaid Plan in 2003 in response to critical reviews from the Center for Medicare and Medicaid Services (CMS), as well as implementation of an External Quality Review (EQR) process in 2004. They also include the enhanced oversight and standardized managed care requirements for RSNs established legislatively by E2SHB 1290 and the 2005-06 RSN procurement process.

The Current Federal Climate. These changes also took place in the context of wider changes at the federal Center for Medicare and Medicaid Services (CMS) that affected all states delivering Medicaid managed care services. These included: August 2002 changes in the required rate calculation methodology from upper payment limits (UPL) to actuarially sound rates, enhanced quality standards for managed care plans set by the Balanced Budget Act of 1997 (implemented in August 2003 under 42 CFR 438), enhanced scrutiny of rehabilitative services, and additional scrutiny under the Deficit Reduction Act of 2005. This federal context was particularly relevant to the development of two system features that are a major focus of this report: (1) The current 18 modalities defined under the Rehabilitative Services section of Washington's Medicaid State Plan, which were developed in response to CMS concerns expressed immediately following the shift from the UPL rate methodology to the actuarially sound rate requirements, and (2) The Access to Care Standards which govern both eligibility and medical necessity determinations for the current Medicaid system, which were developed in response to a contingency from CMS on Washington's 2001 waiver renewal.

Washington's Current Medicaid Managed Care System. Washington's Medicaid mental health benefit is primarily structured by four components from Washington's Medicaid State Plan: Inpatient Hospital Services, Under 21 Inpatient Services, Physician Services, and Rehabilitative Services. The primary focus of the RSN's PIHP programs is the 18 Rehabilitative Services modalities. In addition to the State Plan services, Washington is able to provide three additional non-traditional service types defined within its waiver under the authority of Section 1915(b)(3): Mental Health Clubhouse, Respite, and Supported Employment.

Comparisons with Other States: Arizona, Colorado, New Mexico, and Pennsylvania. Four states were selected for comparison to Washington that, across their various features, represent most of Washington's current system components. These states also allow us to look at Medicaid benefit designs funded at levels comparable to Washington's (AZ and CO), as well as much lower (NM) and much higher (PA). That being said, several structural features are unique to Washington:

- Washington's eligibility requirements include the DC:0-3 standards for infants and toddlers, allowing more diagnostic flexibility for early childhood mental health needs.

- Washington is the only state of the five that imposes functional impairment requirements as a means of determining service eligibility. Other states incorporate impairment scores such as the GAF into discrete level of care guidelines for medical necessity, but none require such impairment for entry into the system.
- Washington is the only state of the five (and the only 1915(b) waiver state of which we are aware) that holds its managed care organizations to be at-risk for acute inpatient care, but only requires them to coordinate the delivery of such care, rather than directly deliver the service through their regional networks.
- Washington operates independent managed care plans with very relatively few covered lives, including four regions with fewer than 25,000 lives and six with fewer than 60,000. Of the comparison states reviewed, none operate regions with fewer than 40,000 covered lives and only Colorado operates regions with fewer than 60,000 lives.

Medicaid State Plan and Waiver (MSP&W) Recommendation #1: Do not propose any changes to CMS regarding the structure of Rehabilitative Services within Washington's Medicaid State Plan. Our analysis of Washington's State Plan found that the language of the 18 Rehabilitative Services modalities is sufficiently flexible to promote all of the prioritized best practices summarized in the previous major section of this report. Furthermore, in light of the enhanced scrutiny of Rehabilitative Services that CMS has engaged in over the last two years, resulting in actions by CMS in dozens of states either limiting service flexibility or disallowing current costs under their Rehabilitative Services option, we do not recommend proposing any State Medicaid Plan change to CMS involving Rehabilitative Services. However, if CMS adopts new regulations for Rehabilitative Services under development at the time of this report (July 2007), Washington State will need to revisit the need for possible State Plan changes to respond to those regulations.

While no changes are currently recommended in the language of Washington's Medicaid State Plan, we offer several recommendations regarding implementation of the State's 1915(b) Waiver.

MSP&W Recommendation #2: Develop statewide standards for continuing care and discharge under ACS in order to shift the utilization management focus of RSNs from front-end restrictions for all enrollees to proactive care management of services for enrollees with intensive, ongoing needs. This will require the development of statewide medical necessity standards for all levels of care, including criteria for initial and concurrent reviews. It is our opinion that Washington's current waiver, combined with the Balanced Budget Act of 1997 requirements under 42 CFR 438 implemented in Washington under E2SHB 1290, gives MHD the authority to proceed with more refined and standardized implementation of the ACS for the Medicaid benefit. The current implementation of the standards is problematic, particularly their exclusive focus on front-end access to care in general and their lack of (1) standards for continuing access, (2) differential criteria for access to levels of care more intensive than routine outpatient, and (3) formal mechanisms whereby ACS numeric functioning score cut-offs can be overridden based on clinical assessment, medical necessity, and individual need.

The current ACS standards include only criteria for limiting front-end access across the board. As such, they are a crude tool for managing care, focusing utilization management resources almost entirely on front-end limitations to outpatient care and shifting the focus of utilization management too much toward management of low-intensity, low cost outpatient care rather than more expensive levels of care such as day services, long-term case management, and residential services. Other states and their managed care organizations (MCOs) have generally evolved the focus of their utilization management activities away from across-the-board front-end restrictions in order to focus limited care management resources on more expensive services. This approach has generally been found to be more cost-effective over time, with any increase in service use more than offset by: (1) better use of utilization management resources for high-end cases, (2) savings through earlier intervention, and (3) reductions in the cost of managed care oversight.

MSP&W Recommendation #3: Prior to the next waiver submission, conduct a full actuarial analysis of the financial impact of revising GAF and C-GAS minimums for routine outpatient care. If financially feasible, raise the GAF and C-GAS minimums to at least 70 for all covered diagnoses. Currently, there is no substantive mental health benefit for Medicaid enrollees outside of the Healthy Options program, an important subgroup since all disabled adults fall outside the Healthy Options program. The most efficient way to extend coverage to these individuals would be to relax the functional requirements for ACS. The primary barrier is that this is likely to cost more money. If these criteria are relaxed, multiple informants reported that there would be a significant increase in referrals to RSNs. However, given recent benefit changes for these programs (the recent expansion of Healthy Options and fee-for-service benefit limits from 12 to 20 visits annually and expanding the types of eligible providers), eligible providers in RSN networks are now able to provide these additional services. Therefore, it is not clear what additional costs would be entailed by integrating these fee-for-service benefits within the RSN structure.

MSP&W Recommendation #4: Revise Current RSN Contract Requirements for Statewideness and Provide Definitive Guidance to RSNs on Implementation. To better reflect all pertinent federal standards, we recommend that the language of the RSN contracts be revised from an emphasis on statewideness under 42 CFR 41.50 to an emphasis on network adequacy under 42 CFR 438.206 and 438.207. This will shift the focus of RSN requirements so that they must demonstrate how needs are documented and met, rather than simply document that the network includes a provider from somewhere in the state that provides a given modality.